

True Resolutions Inc.

An Independent Review Organization
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NOTICE OF INDEPENDENT REVIEW DECISION

DATE NOTICE SENT TO ALL PARTIES:

Sep/24/2012

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE:

Outpatient lamiectomy at right L4/5

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION:

Board Certified Orthopedic Spine Surgeon, Practicing Neurosurgeon

REVIEW OUTCOME:

Upon independent review, the reviewer finds that the previous adverse determination/adverse determinations should be:

Upheld (Agree)

Overturned (Disagree)

Partially Overturned (Agree in part/Disagree in part)

Provide a description of the review outcome that clearly states whether medical necessity exists for each health care service in dispute.

INFORMATION PROVIDED TO THE IRO FOR REVIEW:

ODG - Official Disability Guidelines & Treatment Guidelines
Notice of utilization review findings 08/15/12

Notice of utilization review findings 08/28/12

Office notes 05/24/12-08/04/12

Orthopedic evaluation 06/19/12

CT myelogram lumbar spine 08/02/12

Pre-authorization request 08/10/12

PATIENT CLINICAL HISTORY [SUMMARY]:

The claimant is a male. Records indicate the claimant stepped down off a tractor and felt sensation in his back with pain down his right posterior thigh stopping at approximately the knee. Claimant was treated conservatively with medications, physical therapy, and epidural steroid injection. MRI of the lumbar spine was noted to show right paracentral disc protrusion with possible impingement on the L4-5 nerve roots. CT myelogram performed 08/02/12 revealed multilevel degenerative disc disease and spondylosis most notably at L4-5 with a prominent broad based disc bulge with moderate facet hypertrophy and ligamentum flavum thickening producing moderately severe spinal stenosis with prominent bilateral foraminal stenosis. Examination performed 08/04/12 reported gait is normal. Station is normal. The claimant is able to tandem gait. Romberg is negative. There is no clothing or cyanosis. There is no weakness in the upper extremities or lower extremities. Tone is normal. There is no cog wheel rigidity or spasticity. Claimant has back pain that radiates into the lower extremity on the right hand side with positive straight leg raise test. He has mild weakness of the extensor hallucis longus and tibialis anterior on the right. Reflexes are symmetric. Plantars are flexor. There is no ankle clonus. Sensory exam to light touch is normal.

A request for outpatient laminectomy on the right at L4-5 was non-authorized per utilization review dated 08/15/12 noting that the claimant has minimal correlation between the MRI and a myelogram, minimal weakness of the EHL and no sensory changes. The straight leg raise apparently causes pain in the back, not the leg, therefore it's not positive. EMG may be helpful in adding more information but the evidence of a significant nerve root involvement is lacking. Therefore medical necessity of the requested procedure was not established.

A reconsideration request for outpatient laminectomy right L4-5 was non-authorized per review dated 08/28/12, noting that while the claimant does appear to have clinical signs of an L5 nerve root decompression that fulfill Official Disability Guidelines requirements for the requested procedure, the reviewer was concerned that symptoms could also be coming from the right hip. Before approval of the requested surgery, the results of orthopedic hip examination and right hip injection would need to be reviewed. If the latter gave good pain relief, then the hip problem should be addressed before proceeding with back surgery. At this time the requested procedure is denied.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION:

Based on the clinical information provided, the proposed outpatient laminectomy at right L4-5 is supported as medically necessary. The claimant sustained an injury when he twisted his low back when he was stepping off of a tractor. He complains of low back pain that radiates into the right hip and into the right buttocks. Records indicate the claimant was treated conservatively with medications, physical therapy, and epidural steroid injection without resolution of symptoms. It was noted the claimant also had an injection into the hip and subsequently been cleared by orthopedics. MRI of the lumbar spine was noted to show right paracentral focal posterior disc protrusion at L4-5 which could impinge the right L4-5 nerve roots. It was noted claimant has congenitally small canal although no significant canal stenosis is seen. CT myelogram of the lumbar spine was performed 08/02/12 and revealed multilevel degenerative disc disease and spondylosis most notably at L4-5 with a prominent broad based disc bulge with moderate facet hypertrophy and ligamentum flavum thickening producing moderately severe spinal stenosis with prominent bilateral foraminal stenosis. On examination claimant was noted to have mild weakness of EHL and tibialis anterior on the right, with normal sensation and symmetric reflexes. On examination the claimant was noted to have back pain that radiates into the lower extremity on the right hand side with positive straight leg raise test. Noting that the claimant does have objective evidence of moderately severe spinal stenosis with prominent bilateral foraminal stenosis at the L4-5 level, and noting that his condition has been refractory to all conservative treatment completed to date, with

physical examination findings consistent with imaging, the proposed surgical procedure is indicated as medically necessary. As such prior denials are overturned on IRO.

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

ACOEM-AMERICA COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE

AHCPR-AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES

DWC-DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES

EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN

INTERQUAL CRITERIA

MEDICAL JUDGEMENT, CLINICAL EXPERIENCE, AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS

MERCY CENTER CONSENSUS CONFERENCE GUIDELINES

MILLIMAN CARE GUIDELINES

ODG-OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES

PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR

TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS

TEXAS TACADA GUIDELINES

TMF SCREENING CRITERIA MANUAL

PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)

OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)